Emergency Involuntary Procedures (EIP) Work Group
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
March 13, 2020 ~ 10:30am – 12:00pm

Attendance: Chris Donnelly, David Horton, Jennifer Rowell; DMH; Michael Sabourin, VPS.

Phone: Karen Crowley, VCPI; Katie Ruff, UVMMC, Terri Graham, CVMC, Jeremy Smith, VPCH.

Welcome and Introduction: Introductions took place around the table. Review of agenda.

Updates – Six Core Strategies

As of February, VCPI did get a Grant from DMH and worked out a scope of work and devised the following plan:

2-day training in Vermont, not a well-planned training yet on what we will cover. We are working with the sites for who they are sending and the best agenda. It will be a good intro, more in-depth than the one-day training. We have about 75 people so far who will be coming. Also got more funding to work more intensively with a couple of sites.

Data Review – David Horton and Chris Donnelley
Link: https://mentalhealth.vermont.gov/about-us/boards-and-committees/emergency-involuntary-procedures-review-committee

(p5) There is an increase in emergency meds & a decrease in mechanical restraints in comparison to last quarter.

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(p7) Most EIPs are performed on level 1 units. There were 1.8 procedures per episode this quarter. The total amount of time for EIPs is down slightly this quarter in comparison to last quarter.

(p8) A vast majority of adult patients did not receive an EIP in general (80%). Most non-level 1 patients had 4 or less EIPs. Most patients receiving EIPs are level-1.

(p10) Not a great deal of difference between last quarter and this quarter in level-1 rates. All level-1 rates are slightly higher than the national average.

(p11) Virtually no change since last quarter.

(p12) All three rates went down per 1k patient hours

Public Suggestion: have charts on pages 3 – 5 become 13 month bar charts. Was advised that prior reports are available online for comparison.

Comment: UVMMC data shows for a while it is decreasing due to a decrease in census and increase in medical acuity.

CVMC Presentation –

Inpatient psych unit is a small unit of 15 beds, adult only. Majority are voluntary. We are almost always full and in the ED we have 8 folks currently. Our unit was renovated in 2002 and quite outdated now, but still a highly functional unit.

With the new build, we would have 40 beds. We spent a lot of time developing new units, how to staff them, programs. We included in that work a new ED, the proposal that was brought to the board was declined because it was over budget. We are going back to the drawing board, taking the renovation of ED out of the picture for now.

For COVID-19, found ligature resistant hand sanitizer for the unit and have them on order. Can Terri share with Jen to where you are ordering that from?

Working on lots of Coronavirus planning in hospital right now. We have no negative pressure units, we have decided we will have no infectious patients on the unit. When they are in the ED suicidal, we are not going to send them home, but what if they are both, where do they go? Q: do you have a team that do consults for Psych? Yes screeners. Our work around is we have a consult team that meet their psych needs when their primary needs are medical.

Going live with EPIC in October.

Had a CMS survey a month ago due to a patient complaint and there were some findings we are working through; one we were not doing a good job of documenting the medical issues from the 1-hour face to face. Redid forms and more training with staff.

We have had 6 episodes of manual restraint since the survey, 5 involuntary meds and 1 mechanical restraint that lasted about 40 minutes.

No questions or comments.

Coronavirus – any thoughts?

- Empty ambulance garage at the ED, inside bays, built 3 negative pressure rooms as an extension of the ED for some testing, also 7 drive through tests who were screened by their provider and felt they needed to be tested. They give info on how to self-quarantine at home. Barriers to avoid: I think a smaller hospital is easier to get things up and running. Incident command is open.
- VPCH – difficulty how we would manage someone who would be affected. Any open rooms are seclusion rooms and those aren't options. We hired an infectious control nurse last summer and also working with CVMC who has been a tremendous help. Visitor protocol from UVMMC that they got for a resource. We do screen visitors but that includes everyone even the Judge, etc.
- UVMMC put in place the visitor's protocol. We have the infrastructure on our unit to be able to screen visitors. It will be challenging for the patients and need to support the patients.

Public Comments

No public comments